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Chapter I

Review of the Literature

There are five main characteristics that describe individuals with severe mental illnesses from a psychosocial standpoint. The first is a high vulnerability to stress; the second is deficiencies in coping skills; the third is extreme dependency; the fourth is difficulty in the competitive job market; the fifth is difficulty with interpersonal relationships (Hellkamp, 1993b). These specific characteristics describe deficits in functioning across most aspects of one’s life. From the standpoint of the Diagnostic and Statistical Manual of mental disorders (DSM), individuals described as having a severe mental illness are those who have been diagnosed with the following: schizophrenia, delusional disorders, some mood disorders, and certain personality disorders (Hellkamp, 1993b).

Individuals with severe mental illnesses face many challenges in society. Individuals with severe mental illnesses have suffered through life with many social, economic, and personal difficulties (Maxmen & Ward, 1995). These illnesses and their accompanying symptoms can debilitate and impair an individual’s ability to adequately care for themselves, manage their household, maintain interpersonal relationships, and/or successfully keep up with the demands of school or work, thus making it difficult to function autonomously and as a contributing member of society (Garske & MacReynolds, 2001).

Social Impairments

The symptoms of severe mental illnesses often decrease an individual’s ability to function socially. Mueser, Glynn, and McGurk (2006) described limited social functioning as having direct
effects on the ways in which individuals interact with others, perceive others, and non-verbally attend to others. These individuals tend to exhibit social awkwardness and/or display odd or inappropriate behavior in social situations (Rutman, 1994). Also, these individuals often lack assertiveness in everyday interactions, sometimes leading to exploitation by others and unreciprocated interpersonal commitments (Bond, Campbell, & DeLuca, 2005). The nature of severe mental illness leads to unpredictability in various aspects of one’s psychosocial functioning, including difficulty controlling emotion, impulsiveness, irritability, and deficits in reading social cues (Rutman, 1994). Such unpredictability can cause hopelessness and frustration, feelings that can lead to unstable social connections (Rutman, 1994). High vulnerability to stress, which is one of the psychosocial characteristics of individuals with severe mental illness, can further contribute to difficulties in social functioning in everyday life (Bond et al., 2005). An individual’s capacity to function socially seems to influence many aspects of his or her life, but is compromised by severe mental illness.

Vocational Impairments

Various research studies, cited by Mueser et al., 2006, discussed the low rates of competitive employment in individuals with severe mental illnesses, schizophrenia in particular. Many individuals with severe mental illness do not ever fully recover in a vocational domain to a point at which he or she was prior to the onset of illness (Mueser et al., 2006). Difficulty maintaining education and following the structure of a job often lead to vocational impairments. Also, as discussed earlier, social functioning is affected by severe mental illness, which can impact job performance and ability to obtain and maintain a job (Mueser et al., 2006). Rutman (1994) cited several studies that found that individuals who have severe mental illnesses may not have as high a capacity in regard to work related characteristics, such as ability to perform various
tasks, punctuality, completion of directions, and appearance and grooming. These studies cited by Rutman (1994) also found that the unpredictable nature of severe mental illnesses makes it difficult to find and keep jobs. Specifically, the way that individuals react (i.e., hopelessness, frustration) to inconsistent aspects of their disorder may affect their ability to effectively engage in work related tasks (Rutman, 1994). It seems that social and vocational impairments greatly affect the overall ability for individuals with severe mental illnesses to function in the social and vocational world. The ease with which these individuals function on a daily basis seems to be dependant on some degree of relief from these impairments.

*Treatment of Severe Mental Illness*

*Medication*

A very common treatment choice for severe mental illnesses is antipsychotic medication. Some of the individuals who have been prescribed medication have had significant decreases in frequency and intensity of psychotic symptoms (Stroup, Kraus, & Marder, 2006). This has remained the treatment of choice for individuals who have severe mental illnesses, as many of their psychotic symptoms are controlled (Lehman et al., 2004; Stroup et al., 2006).

According to Lehman et al. (2004), current research on the treatment of individuals with severe mental disorders, particularly schizophrenia, mainly focuses on symptom and relapse control. However, based on the stressful and debilitating nature of these illnesses, the various behavioral impairments that these individuals have experienced are not fully treated by medication. For example, Penn, Waldheter, Perkins, Mueser, and Lieberman (2005) contended that complete reliance on the “narrow” medical model of psychopharmacological treatment is not sufficient in enabling the individual to functionally recover from psychosis and the impairments that result from severe mental illnesses. Past research studies, cited by Mueser and Noordsy...
(2005), surveyed individuals in psychopharmacological practices in the U.S. and found that individuals are being prescribed increasing amounts of medications to treat individuals’ psychotic symptoms, which increases the likelihood of side-effects. This study focused on treating the psychotic symptoms, with little focus on treating the lasting impairments that result (Mueser & Noordsy, 2005). With this in mind, reasons for limited use of adjunctive interventions that could decrease the amount of prescribed antipsychotic medications are unclear.

Until recently, preventing hospital relapse and controlling psychotic symptoms were the limited goals in the treatment of severe mental disorders, as meeting these goals was considered to be sufficient in treatment (Mueser et al., 2006). Current research on modern day intervention goals include improvement or recovery from the various impairments that can continue to exist even after the acute psychotic symptoms are controlled (Bond et al., 2005; Csemansky, 2002; Hellkamp, 1993b).

**Therapies**

Cognitive behavioral therapy is a highly empirically researched treatment for severe mental illness. Tarrier et al. (1998) reported the findings of a study that delivered cognitive behavioral therapy twice a week for ten weeks, compared to delivering individual supportive therapy and routine care. These authors found that there was more improvement in number and severity of positive symptoms in the group treated with cognitive behavioral therapy than the individual supportive therapy and routine care groups at short term follow up (Tarrier et al., 1998). Also, the findings suggested utility in both supportive and cognitive behavioral therapies in reducing relapse rates. Tarrier (2008) also cited several meta-analyses, which typically examines a variety of studies across the literature in a given area, which provided consistent empirical evidence that CBT for individuals with schizophrenia decreases positive symptoms in
psychotic patients. Specifically, utilizing CBT with individuals with severe mental illnesses, schizophrenia in particular, focused on helping clients to divert their attention from their hallucinations and/or to examine alternative explanations for their experiences (Tarrier, 2008). CBT methods also focus on family intervention, hospital relapse prevention, self-esteem enhancement, and challenging of irrational fears that lead to problematic behavior.

Pilling et al. (2002) conducted a meta-analysis to assess the effectiveness of cognitive behavior therapy and family therapy that was assessed through various studies in the literature. This meta-analysis showed that cognitive behavioral therapy can be an effective treatment option, but did not improve relapse or rehospitalization rates for individuals with severe mental illness (Pilling et al., 2002). This meta-analysis also found that family therapy showed improved outcomes of psychosis and hospital admission as well as improved medication compliance. Neither of the studies discussed improvements in everyday functioning socially, vocationally, or emotionally. Despite the positive findings of these studies, the findings were inconclusive evidence for the effectiveness of cognitive behavioral therapy and did not measure and/or address improvement of quality of life for individuals with severe mental illness.

Psychodynamic psychotherapy is another treatment for individuals with severe mental illnesses. Maxmen and Ward (1995) discussed the outcome of psychotherapy as the client having "developed more realistic and flexible ways of dealing with and reconciling personal and environmental demands" (p. 92). Psychodynamic psychotherapy focuses on methods of coping as well as insight into various reactions and motivations for behaviors (Hellkamp, 1993b). However, there is controversy present in the literature regarding the effectiveness of psychodynamic psychotherapy for the treatment of individuals with severe mental illness. Specifically, Gottdiener (2006) conducted a meta-analysis to assess the reported effectiveness of psychodynamic psychotherapy.
psychotherapy for treatment of individuals with schizophrenia, one of the most severe of mental illnesses. Gottdiener (2006) concluded that individuals treated with psychodynamic psychotherapy significantly improved over time. However, there are many opinions in the literature regarding psychodynamic psychotherapy. Specifically, Hellkamp (1993b) cited comprehensive studies (i.e., Karon, 1991; Pollack, 1991) in the literature providing empirical support for psychodynamic psychotherapy as an effective treatment for the severely mentally ill population. However, these studies are scattered in the literature, and as a result, the effectiveness of psychodynamic psychotherapy for treatment of severe mental illnesses is not universally known or acknowledged (Hellkamp, 1993b). In regard to severe mental illness, the more widely accepted 'scientific' treatments of severe mental illness, such as medications, do not require that the treating professional fully understand the clients' psychological problems, thus making it difficult for them to fully know how to treat the individual effectively (Karon, 2003).

Conclusively, engaging in psychodynamic psychotherapy with a client with severe mental illness provides the client with the comprehensive understanding and resolution of the underlying issues of their illness and failing to engage in this treatment is neglectful to the client (Karon, 2003). The literature does not provide enough “good” studies to definitively make conclusions regarding the effectiveness of psychodynamic psychotherapy for individuals with severe mental illnesses, but those existing do show promise (Karon, 2003). For example, this author discussed a study of inpatient clients at St. Elizabeth's hospital who had been there for 15 years. Conclusively, psychotherapy led to discharge significantly more so than control inpatients who were receiving medication only (Karon, 2003).
Summary of Pharmacotherapy and Psychotherapy for Treatment of SMD population

There are various methods of treatment and intervention for individuals with severe mental illness discussed in the literature that have been empirically supported to improve the lives of individuals of this population (Gottdiener, 2006; Karon, 2003; Stroup et al., 2006). Specifically, supportive and cognitive therapies and pharmacotherapy have been shown and suggested to reduce relapse rates and decrease positive symptoms (Pilling et al., 2002; Stroup et al., 2006). Also, psychoanalytic psychotherapies have taught clients greater insight into their experiences and provided them with methods for coping with stress (Hellkamp, 1993). However, the effects of psychotherapies and pharmacotherapy in the treatment of individuals with severe mental illnesses may not fully encompass treatments specific to dealing with all of the impairments of individuals with severe mental illnesses (Farkas, Gagne, Anthony, & Chamberlin, 2005; Gilbert, Miller, Berk, Ho, & Castle, 2003).

Psychosocial Rehabilitation Interventions

Another layer of collaborative treatment for severe mental illness that pays specific attention to psychosocial impairments is psychosocial rehabilitation interventions (PRI). The focus of PRI is to enable the consumers of treatment and their families to be better able to cope with the difficult effects of having a severe mental illness and to work toward becoming/continuing to be a functioning member of society (Bond et al., 2005; Clark & Samnaliev, 2005). According to Stromwall and Hurdle (2003), the main tenet of PRI is to teach skills required for normal functioning in the community to individuals with severe mental illnesses. The goal of PRI is for individuals with severe mental illness to return to the community as a functioning member of society, ultimately achieving recovery (Farkas et al., 2005).
Csemansky (2002) suggested that an individual’s risk for hospital relapse is decreased as a result of the improved impairments in psychosocial functioning and is often long-lasting. PRI, in addition to medication and psychotherapy, has provided significant improvement in social and vocational impairments (Clark & Samnaliev, 2005; Dogan et al., 2004).

**What are Psychosocial Rehabilitation Interventions?**

Different practitioners utilize PRI in various manners, but most tend to adopt the following general objectives: integration into the community, tackling of difficulties with everyday tasks (i.e., hygiene, money management, etc), increase of sense of hope, psychoeducation for the consumer and the family, and a focus on the choices and decision process of the consumer, especially vocationally (Bond et al., 2005). Such elements as social skills training, vocational rehabilitation, psycho-education, family therapy, and cognitive rehabilitation are utilized to achieve recovery (Clark & Samnaliev, 2005; Dogan et al, 2004; Silverstein et al, 2006). The evidence-based practices that compose PRI rigorously integrate the following practices: assertive community treatment, family psychoeducation, illness management and recovery, integrated dual disorders treatment, medication management, and supported employment (Bond et al., 2005). PRI specifically addresses the functional impairments that may not be improved by medication or psychotherapies with the ultimate goal of providing the client the skills and knowledge to function in society.

Researchers focusing on the nature of PRI conceptualize their purpose as based on a recovery oriented mission of treatment (Farkas et al., 2005). These authors discussed the values that provide a basis for treating the impairments that can result from severe mental illness. One of these values is referred to as person orientation (Farkas et al., 2005). This value encompasses the notion that individuals with severe mental illness each have their own unique skills, goals, and
talents that are the driving components in each of their treatment plans. More broadly stated, practitioners who utilize psychosocial rehabilitation interventions focus on the individuality of each client and avoid viewing them as just another patient or case to be treated (Farkas et al., 2005). Practitioners who utilize PRI focus on the specific goal of each client and focus on the impairments that prevent him or her from maintaining a role in society. Farkas et al. (2005) focused on various aspects of the individual and his or her involvement in treatment planning as well as his or her preferences and goals when developing individual treatment. Various studies (Csemansky, 2002; Farkas et al., 2005) have suggested that psychosocial rehabilitation interventions not only contribute to significant improvement in impairments that affect everyday functioning in society, but also can lead to improvements in medication and psychotherapy compliance.

Although studies examining the effects of PRI provide support for significant lasting improvements from severe mental illness, it is still not currently widely used as a major, significant focus of intervention for these individuals. According to Gilbert et al. (2003), only about 19% of individuals diagnosed with psychotic disorders had received any form of psychosocial rehabilitation in the last year.

Use of PRI in private and public sectors of the mental health care system

Stromwall and Hurdle (2003) discussed the status of PRI in the public mental health care system. Specifically, public sector social workers have received exposure to PRI, but little emphasis is given to these interventions by the social work literature despite the fact that social work is a major aspect of the public sector of the mental health care system. However, it is possible that practitioners in the public setting may have more positive attitudes about PRI than other providers, especially private sector practitioners. Seemingly more literature focuses on
increasing emphasis on the recovery model, which is the focus of PRI, in public sector facilities than in private sectors (Barreira & Dion, 1991; Kirsh, Krupa, Horgan, Kelly, & Carr, 2005). Specifically, in an attempt to increase outcomes based on the recovery model framework, Kirsh et al. (2005) found that 42% of the 108 community mental health agencies used the recovery based outcomes method to measure outcomes. While these findings were encouraging, no attempts were made to increase use of the recovery model-based outcomes in the private sectors.

Overall, based on the limited number of studies that focused on increasing use of PRI in both private and public sectors, it seems that public sector practitioners and systems place more importance on this model of treatment, possibly because patients in the private sector are higher functioning and may not require PRI. However, there is virtually no research addressing the attitudes of providers in public and private sectors of the mental health care system.

*Attitudes of Practitioners*

Casper (2005) discussed various characteristics that correlated with the quality of life of a sample of individuals who were being treated for a severe mental illness during his study. Some of these characteristics included the attitudes about PRI of the practitioners involved in treating these individuals. Specifically, positive significant correlations ($r=.16-.45$) were found between measures that described empowerment, quality of life, employment status, and residential status of this population and measures of practitioners' attitudes about PRI (Casper, 2005). The findings regarding positive patient characteristics suggested that clinicians who scored higher on a scale measuring attitudes about PRI may be more likely to treat or refer their patients for PRI services. It seems that positive attitudes about PRI are related to these positive patient characteristics. This finding suggests that it may be important to further examine the research that focuses on attitudes in regard to PRI.
Cnaan and Blankertz (1992) focused on identifying the perceptions that consumers and practitioners have regarding the importance and effectiveness of PRI. These authors surveyed 116 experts who treat individuals with severe mental illness, 72 of whom responded, asking them to identify which elements of treatment of individuals with severe mental illness were the most important of those presented. It was found that practitioners and consumers agreed that the components of treatment necessary in treating psychosocial issues of those with severe mental illness are important (Cnaan & Blankertz, 1992). However, the ways in which they perceive the overall effectiveness of PRI as a specific method of intervention were not addressed. Although there is agreement amongst practitioners and consumers regarding what is important in treating consumers with severe mental illness, PRI may continue to be perceived as secondary interventions to the interventions of medications and psychotherapy (Gilbert et al., 2003).

**Attitudes as an Influence to use of PRI**

Casper, Oursler, Schmidt, and Gill (2002) examined the role that attitudes play in the use of PRI. Casper et al. (2002) suggested that providers’ attitudes about the capabilities of individuals with mental illness may influence one’s use of these interventions, specifically psychosocial rehabilitation. As discussed in the literature (Glasman & Alberaccian, 2006; Marsh & Wallace, 2005), beliefs, congruent with attitudes, can often influence one’s behavior once the evaluative processing is carried out, suggesting that the description of clinician attitudes is important. Various authors (Casper et al., 2002; Cnaan & Blankertz, 1992) have suggested that the belief systems of professionals working with individuals with severe mental illness can have an influence on their decision to implement such interventions.

Song (2007) discussed the effects that practitioner attitudes have on the outcome of implementing and/or effectively working toward the goal of recovery when working with
individuals with severe mental illness. Specifically, these authors described recovery interventions as involving intense human contact and needing the practitioners to instill hope in the consumers with which they work (Song, 2007). The extent to which providers believe in the principles of interventions that have the goal of recovery (i.e., PRI) appears to have an impact on how effectively the consumers are able to carry out PRI or whether the consumers implement these interventions at all. One of the main findings of Song (2007) was that practitioners agreed relatively less with particular statements about PRI than with other statements relating to general aspects of PRI principles. Specifically, attitudes indicated less agreement with the importance of “equipping clients with skills, social change, empowerment and commitment from staff” (Song, 2007, p. 237). The attitudes indicated that the population of practitioners in this study placed less importance on dimensions of PRI that attempt to treat some of the functional impairments that result from severe mental illness than on statements relating to environmental aspects of treatment. This finding indicates that this population’s attitudes about PRI do not fully encompass the components of PRI that lead to recovery. Specifically, obtaining skills, improving social interactions, and being empowered are important components of recovery (Bond et al., 2005; Farkas et al., 2005). Song (2007) also concluded that attitude was the most important predictor of enactment of PRI. However, this study was conducted in Taiwan and involved only practitioners working in hospitals, making it difficult for these results to generalize to the Western population of mental health care providers. Also, it is possible that providers (psychologists, physicians, case managers, etc) may not have a strong belief in the efficacy of psychosocial rehabilitation interventions. Logically, providers will less likely implement a particular intervention if they question the effectiveness of it. It is possible that these attitudes may be associated with psychosocial rehabilitation interventions not being more widely used, despite the literature that
supports its effectiveness and the perception that the elements of psychosocial rehabilitation are important to treatment (Clark & Samnaliev, 2005; Cnaan & Blankertz, 1992; Gilbert et al., 2003).

Attitudes as an Obstacle to the use of PRI

Dhillon and Dollieslager (2000) discussed their attempt to implement PRI practices into an acute treatment unit. Although they did not report the method of collecting data from the hospital staff, they found various barriers to implementation. Specifically, these barriers included the staff’s perceptions that individuals with psychiatric disorders were virtually unable to participate in activities that involved psychosocial dimensions. This ultimately implies that providers may be operating under the notion that there is no point in attempting to implement PRI, as the patients will not be able to utilize them in a way that leads to improvement (Dhillon & Dollieslager, 2000). The perception that PRI was the jobs of recreational therapists was also discussed as an obstacle. This led to the notion that the lack of responsibility for implementing these interventions implied little emphasis on their importance for the providers (Dhillon & Dollieslager, 2000). Finally, they found that many practitioners still operated solely under the traditional biological treatment of severe mental illnesses and did not demonstrate the need for psychosocial and psychological interventions (Dhillon & Dollieslager, 2005). These authors found that some of the factors preventing the use of PRI are related to staff members’ lack of emphasis on the importance of PRI. Mueser and Noordsy (2005) acknowledged that the general perspective of biological psychiatry is that psychosocial treatments of the severely mentally ill population are less relevant than psychopharmacological treatments. This notion may make it less likely that PRI will be incorporated as paramount interventions (Mueser & Noordsy, 2005). It seems that practitioners’ views on the practices and attitudes about PRI may be one of the obstacles to greater use of PRI, but little research examines this issue.
A Measure of Provider Attitudes about PRI

Casper et al. (2002) created a scale to measure attitudes of providers about PRI. These authors collected data on the attitudes, beliefs, and knowledge of the providers, which consisted of members of an organization through community mental health settings.

Attitudes about PRI were gauged by level of agreement with statements on the Psychiatric Rehabilitation Beliefs, Goals, and Knowledge scale (PRBGP). Level of agreement was based on a Likert scale with items ranging from 1-5, with 1 indicating no agreement and five indicating strong agreement with the statements regarding PRI. For example, one of the items reads Psychiatric rehabilitation professionals should be as concerned with clients' quality of life as with their symptoms (Casper et al., 2002). In a separate, more current study by the same author (Casper, 2005) that included a sample of 478 providers, it was found that the measures of attitudes about PRI did not significantly differ from the original sample of 279 from 2002. Based on the samples from Casper's studies from 2002 and 2005, the mean PRBGP score of practitioners fell between response choices undecided and slightly agree. This indicated that attitudes about PRI were, at best, slightly more positive than neutral and did not change over time (Casper, 2005). Also, the providers in the study were reportedly familiar with various authors' work in the area of psychiatric rehabilitation.

Demographic Characteristics of Mental Health Care Providers

In addition to attitudes as possible obstacles to implementing PRI, another possibility to consider is whether there are any characteristics of providers that are related to more positive or negative attitudes about the use of PRI. There has been little research available that assessed demographic characteristics in relation to attitudes about PRI. Gavin et al. (1998) examined belief systems of physicians regarding importance of mental health issues. These authors suggested that
practicing physicians who have been out of training longer with more practicing years of experience have less belief in the effectiveness of mental health interventions and feel more burdened by the mental health needs of their patients than those out of training for shorter amounts of time (Gavin et al., 1998). It was suggested that the more experienced physicians in this study placed more importance on medication than issues relating to mental health. According to Song (2007), physicians held less favorable attitudes toward PRI than other practitioners in the study. It seems possible that these unfavorable attitudes may carry over for psychologists and case managers in regard to the treatment of severe mental illnesses.

Summary

As mentioned above, there has been a great amount of interest shown in the research literature about the use of PRI for treatment of individuals with severe mental illness (Clark & Samnaliev, 2005; Farkas et al., 2005; Hellkamp, 1993b; Lehman et al., 2004). Several authors identified the use of PRI as becoming more of a necessity to treatment (Farkas, et al., 2005; Gilbert et al., 2003; Hellkamp, 1993a; Lehman et al., 2004). The studies have found that in the last several decades, PRI has become more of a topic of interest and research, but other literature (Gilbert et al., 2003) suggested that PRI still may not be a widely used intervention by practitioners and case managers who treat individuals with severe mental illnesses. Smith and Bartholomew (2006) discussed the importance of the influence that attitudes can play in the decision making process of various individuals, in this case, practitioners and case managers who work with the severely mentally ill population. Smith and Bartholomew (2006) suggested that the largest hurdle in the process of treating individuals of this population with the goal of recovery is dealing with the attitudes that are present in clinicians working with this population. However, there has not been a lot of research on these attitudes. Several studies have suggested that
attitudes about PRI is a valuable component to a better understanding of the use of PRI and a better understanding of the practitioners that implement these interventions (Casper, 2005; Chann & Blankertz, 1992; Song, 2007).

According to Bond and Farkas, there are few or no studies of which they are aware that have examined the attitudes of practitioners about PRI (G.R Bond, personal communication, September 20, 2006; M.D. Farkas, personal communication, September 21, 2006). Based on the reviewed literature, only three studies (Casper, 2005; Casper et al., 2002; Song, 2007) address the issue of the need for better understanding of the ways in which the practitioners, both private and public sector, that work with individuals with severe mental illness view psychosocial rehabilitation interventions. Consequently, it seems reasonable to conduct survey research that would contribute to the existing literature.
Chapter II
Rationale and Hypotheses

In addition to their symptoms described by the DSM, individuals with severe mental illness often experience social and vocational impairments as a result of their illness (Mueser et al., 2006). Although medications and psychotherapies have been found to be effective in treating the symptoms of individuals with severe mental illness, there tend to be psychosocial and functional impairments that are left unaddressed. A review of the literature indicates that psychosocial rehabilitation interventions (PRI) have been empirically supported to improve the functional impairments that result from severe mental illness. The literature also suggested that providers who utilize PRI maintain an active interest in the well-being of consumers and their role in society (Casper, 2005; Csermansky, 2002; Farkas et al., 2005). Despite empirical support of effectiveness, PRI has yet to become a universally integrated, meaningful, and implemented aspect of treating individuals with severe mental illness.

A review of the literature has also suggested that providers' attitudes play a significant role in whether or not PRI is utilized (Casper, 2005; Smith & Bartholomew, 2006; Song, 2007). Casper (2005) and Song (2007) found that attitude was the most important predictor of enactment of PRI and that positive practitioner attitudes about PRI are significantly related to positive well-being of their clients. Also, Kirsh et al. (2005) discussed that public sector practitioners have more experience with PRI than private sector practitioners and it seems that the idea that PRI is important to comprehensive treatment is more common in practitioners working in the public sector than the private sector. There is, however, a paucity of research that provides a current
description of the attitudes about PRI of those working with individuals with severe mental illness and no research providing information about the differences between public and private sector practitioners. The literature discussing the general belief systems of mental health care providers about PRI is limited (Casper et al., 2002; Cnaan & Blankertz, 1992; Song, 2007).

The proposed study will examine the current attitudes that mental health care providers in the private versus public sectors have about psychosocial rehabilitation interventions. This will include assessing attitudes of selected practitioners in both private and public sectors of the mental health care system.

The null hypotheses for this study are: 1) There is no statistically significant difference between public sector and private sector providers' attitudes about psychosocial rehabilitation interventions, as based on the PRBGP (2002) total scores. 2) There is no significant difference between providers' attitudes about PRI in the current sample and providers in Casper's original sample (2002), as assessed by the PRBGP total scores. The providers from Casper's sample consist of members of an organization through community mental health settings.

If a significant difference exists between the PRBGP total scores of the current sample and Casper's sample, the following null hypotheses will also be tested: 1) There is no significant difference between attitudes of public sector practitioners on PRBGP total scores and the PRBGP total scores obtained from Casper's study. 2) There is no significant difference between attitudes of private sector practitioners on PRBGP total scores and PRBGP total scores of attitudes obtained from Casper's study.

As a secondary purpose, demographic information will be collected to explore some specific characteristics of practitioners as to provider attitudes about PRI. Since a large number of the providers in the study will be case managers and psychologists, the discipline specific
differences between providers on this scale will be examined. Also of specific interest, based on
the study by Gavin et al. (1998), will be the practitioners’ length of practice years since
graduation. Also, total years working with the SMD population will be examined to include more
descriptive data and to identify any trends. The secondary null hypotheses include the following:
1) There is no significant difference between attitudes of case managers in the public sector,
psychologists in the public sector, and psychologists in the private sector, as measured by PRBGP
scores (Casper et al., 2002). 2) There is no significant difference in PRBGP (Casper et al., 2002)
scores of attitudes about PRI between groups of participants with varying years of experience.
These groups will be defined by splitting the sample at the midpoint of years of experience and
comparing the two groups on the PRBGP total scores (2002).
Chapter III

Method

Participants

Participants for the current study will include mental health care providers, primarily psychologists and case managers, in the private and public sectors of the mental health care system. These individuals will be asked, on a demographic questionnaire, to indicate the setting in which they currently work and then will be included in either the private sector sample or the public sector sample based on their response. Private sector practitioners will include those who indicate on the demographic questionnaire that they primarily work in private practice or in a private psychiatric hospital. Public sector practitioners will include those who indicate on the demographic questionnaire that they work in state-funded settings, such as community mental health settings, state hospitals, and case management programs. If participants indicate that they work in a different setting than those mentioned above (marking ‘other’ on the demographics page and writing in the setting in which they work), they will be identified with the appropriate sector if it is clear where they fit; if not, those participants will be eliminated from the study. Practicing psychologists will be selected as participants from the “Adult General Practice” classification of the 2006-2007 Ohio Psychological Association (OPA) Member Directory. Participants will also include practitioners from a large local mental health agency, mainly consisting of case managers with some other practitioners (e.g., psychiatrists and psychologists).
A power analysis was conducted to determine the sample size that will be needed for this study. According to Jaccard and Becker (1990), to obtain an effect size of .80, a minimum of 21 participants will be needed for each group, for a minimum total of 63 participants.

**Measures**

*Psychiatric Rehabilitation Beliefs, Goals, and Practices*

The attitudes about psychosocial rehabilitation interventions (PRI) will be measured by the “Psychiatric Rehabilitation Beliefs, Goals, and Practices” (PRBGP; Casper et al., 2002, see Appendix A). The PRBGP is a 26-item 5-point Likert agree-disagree scale. Casper et al. (2002) described the rating scale as consisting of anchors that describe the level of agreement for each statement about effectiveness and knowledge of PRI. Total scores on this measure range from 26 as the minimum score to 130 as the maximum score (Casper et al., 2002). Casper et al. (2002) reported that the total mean score from his study was 97.9 (“reflecting a slight upward bias,” p. 226) with a mean item score of 3.76, indicating that the respondents agreed slightly more so than neutral (3.0). This scale has a reported test-retest intraclass correlation of .92 and an overall scale Cronbach alpha ranging from .68-.84, indicating that this is a reliable measure (Casper et al., 2002). The professional role of the provider, number of years utilizing PRI, and the number of leading authors in the field of PRI that were read by the providers significantly predicted positive attitudes about PRI (Casper, 2005). This finding demonstrated the convergent-discriminant validity of the PRBGP, suggesting that this measure does indeed validly measure providers’ attitudes about PRI.

A factor analysis was conducted, revealing a five factor solution with factor loadings for each item ranging from .40-.73 (Casper et al., 2002). The factors include the following: Factor one describes the belief in the consumer’s capacity to make healthy choices; Factor two describes...
the belief in the ways in which severe mental disorders are limiting in daily functioning; all items loading on factor two are reversed scored; Factor three describes the perceived quality of life for individuals with these disorders; Factor four describes beliefs regarding disease oriented treatment of this illness; all items loading on this factor are reversed scored; Factor five describes the beliefs in the “recovery oriented mission” of PRI (Casper et al., 2002).

To gain an understanding of the overall attitudes that practitioners have about PRI, the total scores of practitioners will be utilized. The use of the total scores is intended to obtain an overall value of attitude, belief, and knowledge that each practitioner has regarding PRI.

Demographic Characteristics

Each participant will be asked several questions regarding their professional experience and training (see Appendix B). The characteristics will be used to determine the nature of their training for analysis and description purposes. Specifically, participants will be asked to identify the type of setting in which they primarily work to determine whether they work in the private or public sector of the mental health care system. Participants who indicate that they work in private practice or at a private psychiatric hospital will be included in the private sector group. Individuals who indicate that they work in a community mental health center, state psychiatric hospital, or a case management program will be included in the public sector group. Also, the number of years they have worked in that profession, their profession or professional title, and their education level will be asked. They will also be asked to what extent they have learned about psychosocial rehabilitation interventions in their training, whether they trained at the UC/XU training program consortium, and how they feel psychosocial rehabilitation interventions could be more widely used. They will also be asked the percentage of individuals with whom they
work currently and have worked over the course of their practice who have a serious mental illness.

**Procedure**

The Institutional Review Board of Xavier University will receive a letter describing this study requesting exempt status from full board review. Once the study receives IRB approval at Xavier, IRB approval will be requested at Talbert House. Following approval, survey packets will be mailed to the mental health care providers asking them to rate their agreement or disagreement on items about PRI. The OPA membership list will be obtained through the OPA secretary with student member status. The survey packet to be received by participants will include an informed consent form (see Appendix C), a cover letter explaining the purpose of this study (see Appendices D and E) and a self-addressed, stamped envelope to return to the investigator. The instruments to be distributed to the participants will include the Psychiatric Rehabilitation Beliefs, Goals, and Practices (PRBGP) scale and a demographic page that will request basic demographic information regarding the participants' professional experience. Approximately 5 minutes will be required to fill out the survey questionnaire and demographics page.

A large local mental health agency has agreed to distribute the surveys to the 55 case managers and approximately 10-20 other professionals (i.e. psychologists, psychiatrists) that work in the agency. A meeting was held on 7/2/2007 between the director of quality and clinical services, the head researcher at this agency, and the primary researcher and dissertation chair of this study. The agency gave preliminary approval for the study dependent upon IRB approval.

In order to maintain confidentiality of responses, a master list will be developed with each practitioner being assigned a numerical code that will be placed on each survey. As the surveys are returned, the names will be crossed off the master list. If necessary, a second mailing will
occur two weeks later for those participants who did not respond initially. Once the second mailing has occurred, the master list will be destroyed.
Chapter IV
Proposed Data Analysis

Hypothesis I will be tested by conducting an independent samples t-test to determine whether there is a significant difference between total PRBGP scores obtained from public sector practitioners and private sector practitioners. Hypothesis II will be tested by conducting a one sample t-test, which includes a comparison between an existent value and the mean of a current sample, to determine whether there is a significant difference between the mean total score on the PRBGP (Casper et al., 2002) that will be obtained from the participants of the current study and PRBGP mean total score (98.5) from Casper’s (2005) nationwide study. If a significant difference exists, the two additional hypotheses will be tested by conducting two one-sample t-tests to determine whether a significant difference exists between PRBGP total scores from Casper’s study and private sector practitioners and between PRBGP total scores from Casper’s study and public sector practitioners’ PRBGP total scores.

Secondary Hypothesis I will be tested by conducting a one-way ANOVA to determine any differences between case managers in the public sector, psychologists in the public sector, and psychologists in the private sector. Secondary Hypothesis II will be tested by conducting an independent samples t-test to determine any differences in years of experience between groups of participants. Participants will be divided at the midpoint of their reported years of experience and the two groups will be compared on their PRBGP total scores.
References


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Appendix A

The Psychiatric Rehabilitation Beliefs, Goals, and Practices (PRBGP) is protected by copyright so it is not reproduced in this document. This measure is available through the author, Edward S. Casper, who can be reached at the following address: 520 Second Avenue Apt. 20A. New York, NY 10016.
Appendix B

Demographic Questionnaire

1. In what type of setting do you primarily work? (Please check only one.)

___ Private practice
___ Community mental health center
___ State psychiatric hospital
___ Private psychiatric hospital
___ Case management program
___ Other (please specify) ____________________________

2. What is your profession?

___ Case Manager
___ Psychologist
___ Psychiatric Nurse
___ Psychiatrist
___ Physician (not psychiatrist)
___ Social worker
___ Counselor
___ Other (please specify)

3. How many years have you worked in this profession?

___

4. Education (Degree):

___ High School
___ Associates
___ Bachelors
___ Masters
___ Doctoral
___ Medical

5. In your professional training, were you taught psychosocial rehabilitation intervention skills and concepts?

___ Not at all
___ Yes, but not in depth
___ Yes, on a conceptual level
___ Yes, on a conceptual level and under supervision in an applied manner
6. If you trained at the University of Cincinnati or Xavier University in your graduate training, were you a member of the Multidisciplinary Training Program Consortium on severe mental disorders, funded by ODMH? Yes ___ No ___

7. Throughout the course of being in practice, what percentage of the individuals with which you worked would you consider being severely mentally ill? ______

What percentage of the individuals with which you work currently would you consider being severely mentally ill? ______

8. How do you think Psychosocial Rehabilitation Interventions could be improved or more widely used? (Check all that apply)

___ Increase available funding
___ Improve training for PRI
___ Education for practitioners
___ Increase knowledge of efficacy of PRI
___ Other (please specify) _______________

______________________________
Appendix C

Informed Consent

I agree to take part in this study conducted by Gina M. Muehlheim, M.A., a doctoral student in clinical psychology from Xavier University. This study examines attitudes, beliefs, and knowledge about Psychosocial Rehabilitation Interventions. Participation in this study will contribute information to the literature to help improve psychosocial treatment of individuals with severe mental illnesses.

I understand that participation in this study is completely voluntary and I may choose to cease participation at any time.

If you have any questions about this project, Gina Muehlheim can be reached at 330-310-2208. Her research is supervised by David T. Hellkamp, Ph.D., Professor of Psychology, Xavier University, who can be reached at 513-745-1044.

Your name and responses to this study are completely confidential. The results will be reported in group formats. No individual names or scores will be identified.

I understand that I will not receive any financial compensation for my participation in this study. By participating, I will be promoting knowledge regarding Psychosocial Rehabilitation Interventions.

I fully understand the nature of this study and agree to participate. My consent is implied through my participation.
Appendix D

Cover letter for Public Sector

Dear Talbert House Professionals,

Enclosed you will find a survey that asks you to answer questions regarding your attitudes, beliefs, and knowledge about Psychosocial Rehabilitation Interventions as well as some questions about your professional training and experience. We would like to encourage you to take the 5 minutes or less to complete this survey. When you are finished, place it in the self-addressed envelope and mail it back as soon as possible. We want to thank you in advance for your participation.

Sincerely,

Gina Muehlheim, M.A. 
Doctoral Student in Clinical Psychology
Xavier University

David T. Hellkamp, Ph.D.
Professor of Psychology
Xavier University
Appendix E

Cover Letter for Private Sector

Dear Ohio practicing psychologists,

Enclosed you will find a survey that asks you to answer questions regarding your attitudes, beliefs, and knowledge about Psychosocial Rehabilitation Interventions as well as some questions about your professional training and experience. We would like to encourage you to take the 5 minutes or less to complete this survey. When you are finished, place it in the self-addressed envelope and mail it back as soon as possible. We want to thank you in advance for your participation.

Sincerely,

Gina Muehlheim, M.A.  
Doctoral Student in Clinical Psychology  
Xavier University  
Student Member of OPA

David T. Hellkamp, Ph.D.  
Professor of Psychology  
Xavier University  
Former President of OPA
Chapter V: Dissertation

Abstract

This study examined private and public sector mental health care providers’ attitudes about psychosocial rehabilitation interventions (PRI). A sample of 139 providers completed surveys concerning their attitudes about PRI in treating severely mentally disabled (SMD) individuals. Results revealed no significant difference between private and public sector providers, both groups reporting neutral attitudes. This study revealed less positive attitudes than a previous study (Casper, 2005) with lower attitudes for both sectors. No significant differences were found between providers with varying years of experience or between case managers, public sector psychologists, and private sector psychologists. While results indicate no differences in attitudes about PRI between providers who work with the SMD population and those who do not, psychometric issues question the survey’s reliability.
Private and Public Sector Providers' Attitudes about Psychosocial Rehabilitation Interventions

Individuals with severe mental disorders (SMD) face many challenges in society. These individuals have experienced a life with many social, economic, and personal difficulties (Maxmen & Ward, 1995). SMD and their accompanying symptoms can debilitate and impair an individual’s ability to adequately care for his/herself, manage his/her household, maintain interpersonal relationships, and/or successfully keep up with the demands of school or work, thus making it difficult to function autonomously and as a contributing member of society (Garske & MacReynolds, 2001). In the social realm, the nature of SMD leads to unpredictability in various aspects of one’s psychosocial functioning, including difficulty controlling emotion, impulsiveness, irritability, and deficits in reading social cues (Bond, Campbell, & DeLuca, 2005; Mueser, Glynn, & McGurk, 2006; Rutman, 1994). Also, according to past research, individuals with SMD have very low rates of competitive employment and often do not ever fully recover in a vocational domain to a point at which they were prior to the onset of illness (Mueser et al., 2006; Rutman, 1994).

Treatment of Severe Mental Illness

A very common treatment choice for SMD, especially schizophrenia, is antipsychotic medication. Some SMD individuals who have been prescribed medication have had significant decreases in frequency and intensity of psychotic symptoms (Lehman et al., 2004; Stroup, Kraus, & Marder, 2006). Medication has remained the treatment of choice for individuals who have SMD, as many of their psychotic symptoms are controlled (Lehman et al., 2004; Stroup et al., 2006). However, much of the current research focuses solely on symptom and relapse control with little focus on treating the lasting impairments that result from SMD (Lehman et al., 2004;
Mueser & Noordsy, 2005). Supportive and cognitive therapies have reduced hospital relapse rates and decreased positive symptoms of schizophrenia (Pilling et al., 2002; Stroup et al., 2006). Also, psychoanalytic psychotherapies have taught clients greater insight into their experiences and provided them with methods for coping with stress (Gottdiener, 2006; Hellkamp, 1993; Karon, 2003; Maxmen & Ward, 1995). From a psychosocial standpoint, treating the psychotic symptoms of a mental illness and increasing client insight are incomplete in helping the individual to functionally recover from psychosis and the impairments that result from SMD (Bond et al., 2005; Csermansky, 2002; Hellkamp, 1993b; Penn, Waldheter, Perkins, Mueser, & Lieberman, 2005). Conclusively, the effects of psychotherapies and pharmacotherapy may not fully address all of the impairments experienced by individuals with severe mental illness (Farkas, Gagne, Anthony, & Chamberlin, 2005; Gilbert, Miller, Berk, Ho, & Castle, 2003).

**Psychosocial Rehabilitation Interventions**

Interventions for SMD that pays specific attention to the psychosocial impairments mentioned above are psychosocial rehabilitation interventions (PRI). The focus of PRI is to enable the consumers of treatment and their families to be better able to cope with the difficult effects of having a SMD with the goal of becoming/continuing to be a functioning member of society (Bond et al., 2005; Clark & Samnaliev, 2005). According to Stromwall and Hurdle (2003), the main tenet of PRI is to teach individuals with SMD the skills required for normal functioning in the community, ultimately achieving recovery.

Csermansky (2002) suggested that improved psychosocial functioning often provides a long-lasting decrease in an individual’s risk for hospital relapse. PRI, in addition to medication and psychotherapy, has provided significant improvement in social and vocational impairments (Clark & Samnaliev, 2005; Dogan et al., 2004).
What are Psychosocial Rehabilitation Interventions?

Researchers focusing on PRI conceptualize the purpose as based on a recovery oriented mission of treatment (Farkas et al., 2005). Different practitioners utilize PRI in various manners, but most tend to adopt the following general objectives: integration into the community, tackling of difficulties with everyday tasks (i.e., hygiene, money management, etc), increase of sense of hope, psychoeducation for the consumer and the family, and a focus on the choices and decision process of the consumer, especially vocationally (Bond et al., 2005). Such elements as social skills training, vocational rehabilitation, psycho-education, family therapy, and cognitive rehabilitation are utilized to achieve recovery (Clark & Samnaliev, 2005; Dogan et al., 2004; Silverstein et al., 2006). Practitioners who utilize PRI focus on the specific goal of each client and specifically address the functional impairments that may remain unaddressed by medication or psychotherapies with the ultimate goal of providing the client the skills and knowledge to function in society.

Various studies have suggested that psychosocial rehabilitation interventions not only contribute to significant improvement in impairments that affect everyday functioning, but also can lead to improvements in medication and psychotherapy compliance (Csermansky, 2002; Farkas et al., 2005). Although studies examining the effects of PRI provide support for significant improvements for individuals with SMD, it still appears to be less frequently widely used as a major, significant focus of intervention than other treatments. According to Gilbert et al. (2003), only about 19% of individuals diagnosed with psychotic disorders had received any form of psychosocial rehabilitation in their reported last year of treatment.
Use of PRI in private and public sectors of the mental health care system

Seemingly more literature focuses on increasing emphasis on the recovery model in public sector facilities than in private sectors (Barreira & Dion, 1991; Kirsh, Krupa, Horgan, Kelly, & Carr, 2005). Recent research in this area has focused on understanding and increasing the use of the recovery model and psychosocial treatment of individuals with SMD (Kirsh et al., 2005; Stromwall & Hurdle, 2003); however these studies mainly focused on improving such outcomes in the public sector without much focus on the private sector. Also, Coursey et al. (2000) discussed the need for an increase in a universal description of the attitudes of public sector providers regarding treatment of individuals with SMD. Although these authors evaluated the attitudes which would fit the current literature, evaluation of the attitudes were only carried out on public sector providers.

Overall, based on the limited number of studies that focused on increasing use of PRI in both private and public sectors, it seems that public sector providers may place more importance on this model of treatment. However, there is virtually no research assessing the attitudes of providers in the private sectors of the mental health care system and limited research assessing attitudes of public sector providers.

Attitudes of Practitioners

Casper (2005) found that attitudes of mental health care providers working with individuals with severe mental illness were significantly positively correlated with their patients' quality of life. This finding suggests that providers' attitudes are important in the treatment of individuals with severe mental illness. Cnaan and Blankertz (1992) described mental health care providers' perceptions of what is important when using PRI to treat individuals with severe mental illness. More specifically, Song (2007) found that a population of providers placed less
importance on dimensions of PRI that attempt to treat some of the functional impairments that result from severe mental illness than on statements relating to environmental aspects of treatment. This finding indicates that this population’s attitudes about PRI do not fully encompass the components of PRI that lead to recovery. Specifically, obtaining skills, improving social interactions, and being empowered are important components of recovery (Bond et al., 2005; Farkas et al., 2005).

Also, various authors have suggested that the attitudes of professionals working with individuals with severe mental illness influence their decisions about whether to implement PRI (Casper, Oursler, Schmidt, & Gill, 2002; Cnaan & Blankertz, 1992; Song, 2007). Specifically discussing the issue of attitudes impacting use of PRI, Dhillon and Dollieslager (2000) discussed their attempt to implement PRI practices into an acute treatment unit. This study found that one of the barriers to implementation of PRI included the staff’s perceptions that individuals with psychiatric disorders were virtually unable to participate in activities that involved psychosocial dimensions. This ultimately implies that providers may be operating under the notion that there is no point in attempting to implement PRI, as the patients will not be able to utilize them in a way that leads to improvement (Dhillon & Dollieslager, 2000). It is possible that these attitudes may prevent PRI from being more widely used, despite the literature that supports its effectiveness and the perception that the elements of psychosocial rehabilitation are important to treatment (Clark & Samnaliev, 2005; Cnaan & Blankertz, 1992; Gilbert et al., 2003). Overall, current literature suggests that providers’ attitudes about PRI may be one of the obstacles to greater use of PRI, but little research examines this area.
Demographic Characteristics of Mental Health Care Providers

In addition to attitudes as possible obstacles to implementing PRI, another possibility to consider is whether there are any characteristics of providers that are related to more positive or negative attitudes about the use of PRI. There has been little research that assessed demographic characteristics in relation to attitudes about PRI. The research that has been done suggested that both mental health care providers’ discipline as well as amount of time in the field of mental health care could impact their attitudes about PRI (Gavin et al., 1998; Song, 2007).

Overall, a great amount of interest exists in the literature about PRI for treatment of individuals with severe mental illness (Clark & Samnaliev, 2005; Farkas et al., 2005; Hellkamp, 1993b; Lehman et al., 2004). Several authors identified the use of PRI as becoming more of an effective intervention for treatment of the SMD population as based on review of outcomes studies of SMD individuals’ improvement of functional impairments (Farkas et al., 2005; Gilbert et al., 2003; Hellkamp, 1993a; Lehman et al., 2004). Although these studies did not provide comparative analyses between PRI and other types of therapies, improved psychosocial functioning in individuals with SMD was consistently supported. The studies have found that in the last several decades, PRI has become more of a topic of interest and research, but other literature (Gilbert et al., 2003) suggested that PRI still may not be a widely used intervention by providers who treat individuals with severe mental illnesses. Smith and Bartholomew (2006) suggested that a significant hurdle in the process of treating SMD individuals with the goal of recovery is dealing with the attitudes, especially negative ones, that are present in clinicians working with this population. However, there has been little research on these attitudes. Several studies have suggested that attitudes about PRI is a valuable component to a better understanding.
of the use of PRI and a better understanding of the providers who implement these interventions (Casper, 2005; Cnann & Blankertz, 1992; Song, 2007). According to Bond and Farkas, there are few or no studies of which they are aware that have examined the attitudes of practitioners about PRI (G.R Bond, personal communication, September 20, 2006; M.D. Farkas, personal communication, September 21, 2006).

The current study focused on comparing private and public sector providers’ attitudes about PRI. Based on the reviewed literature, only three studies (Casper, 2005; Casper et al., 2002; Song, 2007) address the issue of the need for better understanding of the ways in which the providers, both private and public sector, who work with individuals with SMD perceive psychosocial rehabilitation interventions.

There were three main objectives of the current study. The first was to contribute to the limited research available assessing providers’ overall attitudes about PRI for the treatment of the SMD population. Despite empirical support of effectiveness, PRI has apparently yet to become a universally integrated, meaningful, and implemented aspect of treating individuals with SMD. Because a review of the literature has suggested that providers’ attitudes may play a significant role in whether or not PRI is utilized, a current description of mental health care providers’ attitudes about this treatment would be useful in better understanding mental health care providers.

The second objective was to assess whether there is currently a difference between the providers in the present study and providers from a previous study (Casper, 2005). Because the research on psychosocial rehabilitation interventions continues to increase in the current literature, it would logically be expected that providers from a more recent study would have more positive attitudes. It would be useful to assess whether provider attitudes are similar to those
found by Casper (2005) and that this information might provide a better understanding of the current need for additional training and education about PRI for mental health care providers.

The third objective was to assess whether there are differing attitudes between providers in public sectors of the mental health care system and providers in the private sector. Kirsh et al. (2005) discussed that public sector providers have more experience with PRI than private sector providers and it seems that the idea that PRI is important to comprehensive treatment is more common in providers working in the public sector than the private sector. There is, however, a paucity of research that provides a current description of the attitudes about PRI of those working with individuals with severe mental illness and no research providing information about the differences between public and private sector providers. No empirical studies currently suggest whether private or public sector providers would have more positive attitudes. However, based on the higher frequency of studies that addressed attitudes about PRI, increasing use of PRI, and that public sector providers tend to have more experience with PRI, logically it would be expected that public sector providers would have more positive attitudes about PRI (Barreira & Dion, 1991; Kirsh et al., 2005; Stromwall & Hurdle, 2003). Recent research in this area has focused on understanding and increasing the use of the recovery model and psychosocial treatment of individuals with SMD.

As a secondary purpose, demographic information was collected to explore specific characteristics of providers in relation to provider attitudes about PRI. Since a large number of the providers in the study were case managers and psychologists, the discipline specific differences between these providers on the PRBGP were examined. Also of specific interest, based on Gavin et al.'s (1998) finding that more experienced physicians placed more importance on medication than issues relating to mental health, was the practitioners’ length of practice years since
graduation. Total years working in the mental health care field was examined to include more descriptive data and to identify any trends.

Method

Participants

Practicing psychologists were selected as participants from the “Adult General Practice” classification of the 2006-2007 Ohio Psychological Association (OPA) Member Directory. The participants from this group were selected due to the likelihood that they would include both private and public sector providers. A total of 330 surveys were sent to these providers. Providers from a large mental health agency were also selected as participants, to whom a total of 49 surveys were distributed. Of the surveys distributed, a total of 167 were returned for an overall response rate of 44%. Of these participants, 21 were excluded due to incomplete survey questionnaires. Another three participants were excluded from the study due to not marking the setting in which they primarily worked, making it impossible to determine to what sector they belonged. One participant stated that he/she was retired and therefore did not wish to complete the study to avoid bias. An additional three participants were excluded (those who marked “other” as their primary work setting and wrote in “medical center;” “long-term care;” or both private practice as well as public consulting), as these participants did not specify whether they were in the private or public sector and it was unable to be determined to which sector they belonged. The total number of returned surveys that were usable for the study included 139 mental health care providers from the public and private sectors.

Participants included 139 mental health care providers in the public and private sectors. Of the OPA members (all psychologists), 20 of these providers checked “other” as their primary work setting. Three of these surveys were excluded, as mentioned above. Ten of these settings
were deemed public sector settings, including three VA hospitals, two state prisons, one public nursing home, one public sector MRDD, one public health department, one state government – Ohio department of mental health, one forensic clinic, and a public school. An additional 13 participants marked a setting clearly consistent with a public sector setting (community mental health, state psychiatric hospital, or case management program). Five participants’ settings were deemed private sector, including two nursing homes, one university counseling center, one group practice, and one family practice. An additional 65 participants marked a setting clearly consistent with a private sector setting (private practice or private hospital). Overall, these participants consisted of 70 psychologists currently working in private practice or a private hospital and 23 working in public sector settings, for a total of 93 OPA members. Of the providers from the local mental health agencies, a total of 46 participants, of the 49 participants present at the time of the survey distribution, took place in the study. Overall, there were 69 participants from the public sector, including psychologists (all OPA members), case managers, counselors, and social workers from the local mental health agency.

**Measures**

*Psychiatric Rehabilitation Beliefs, Goals, and Practices*

The attitudes about psychosocial rehabilitation interventions (PRI) were measured by the “Psychiatric Rehabilitation Beliefs, Goals, and Practices” (PRBGP; Casper et al., 2002, see Appendix A). The PRBGP is a 26-item 5-point Likert agree-disagree scale. Casper et al. (2002) described the rating scale as consisting of anchors that describe the level of agreement for each statement about effectiveness and knowledge of PRI. Total scores on this measure range from 26 as the minimum score to 130 as the maximum score with the higher the score, the more positive the attitudes and the lower the score, the less positive the attitudes. Casper et al. (2002) reported
that the total mean score from his study was 97.90, \( SD = 12.84 \) ("reflecting a slight upward bias," p. 226) with a mean item score of 3.76, indicating that the respondents agreed slightly more so than neutral (3.0). This scale has a reported test-retest intraclass correlation of .92 and an overall scale Cronbach alpha ranging from .68-.84, indicating good reliability (Casper et al., 2002). An overall scale Cronbach alpha of .57 was found for the current study. A factor analysis was conducted, revealing a five factor solution with factor loadings for each item ranging from .40-.73 and the five factors accounting for 53% of the variance (Casper et al., 2002).

In the present study, the total scores of providers were utilized. The use of the total scores was intended to obtain an overall value of attitude of each provider regarding PRI.

**Demographic Questionnaire**

Questions regarding participants' professional experience were used to determine the nature of their training for the purpose of operationalizing private versus public sector providers. The demographic questionnaire also asked for the number of years participants have worked in their profession, their profession or professional title, and their education level. Other information about the sample was also asked, including to what extent they have learned about psychosocial rehabilitation interventions in their training, whether they were trained at the UC/XU training program consortium, and how psychosocial rehabilitation interventions might be used more widely. They were also asked to estimate the percentage of SMD clients with whom they currently work as well as estimate the percentage of SMD clients they have worked with over the course of their professional careers (See Appendix B).

**Procedure**

A University Institutional Review Board approved this study at exempt status (see Appendix C). Participants for the current study were asked, on a demographic questionnaire, to
indicate the setting in which they currently work and were included in either the private sector sample or the public sector sample based on their response. No research studies were found that provided a specific definition for private and public sectors. Based on report of the Surgeon General (1999), the private sector of the mental health care system was defined as "services directly operated by private agencies and to services financed with private resources." The public sector was defined as "services directly operated by government agencies (e.g., state and county mental hospitals) and to services financed with government resources (e.g., Medicaid)."

Private sector providers included those who indicated on the demographic questionnaire that they primarily work in private practice or in a private psychiatric hospital. Public sector practitioners included those who indicated on the demographic questionnaire that they work in state-funded settings, such as community mental health settings, state hospitals, and case management programs. If participants indicated that they work in a different setting than those mentioned above (marking ‘other’ on the demographics page and writing in the setting in which they work), they were identified with the appropriate sector when clear where they fit or excluded from the study if their fit was unclear.

The survey questionnaires were mailed to the OPA members asking them to indicate their attitudes concerning the use of PRI when treating SMD individuals. An additional 100 surveys were sent out to a list of public sector psychologists obtained from OPA due to the small number of responses from public sector psychologists. Both lists used were cross-referenced and providers on both lists were not sent a second survey. Each survey packet consisted of an informed consent form (see Appendix D), a cover letter explaining the purpose of the study (see Appendix E), a demographics questionnaire, the PRBGP, and a self-addressed, stamped envelope to return the surveys to the primary researcher. In the event that a second mailing would be
necessary, a master list was developed with each psychologist being assigned a numerical code that was placed on each survey. As the 93 surveys were returned, the names were crossed off. A second mailing was not necessary due to the sufficient number of surveys received; the master list was destroyed.

The IRB of the local mental health agency approved the current study (see Appendix F). Each survey packet consisted of an informed consent form, a cover letter explaining the purpose of the study (see Appendix G), the PRBGP, and a demographics page. The primary investigator attended three different staff meetings that mainly consisted of case managers. At these meetings, the investigator briefly introduced the survey, passed out the survey packets, and immediately received the completed surveys from the staff members.

Results

To assess the difference between the mean scores of public and private sector providers on a measure of attitudes about PRI, an independent samples t-test was conducted. The overall mean total PRBGP scores for private sector providers (M = 75.40, SD = 6.83) and public sector providers (M = 75.77, SD = 5.79) both had an average item score of 2.90, described on the scale point as basically reflecting neutral attitudes. There was no statistically significant difference found between the public and private sector groups of providers on the PRBGP, t(137) = -34, p = .73.

A one-sample t-test was conducted to determine whether there was a difference between the overall mean score on the PRBGP from the current sample (M = 75.58, SD = 6.31) and the overall mean score on the PRBGP from Casper’s (2005) previous study (M = 98.50, SD = 10.80). There was a statistically significant difference between the mean score of the current sample on the PRBGP and the mean score of Casper’s sample, t(138) = -42.79, p < .001. Because of the

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significant difference between samples, additional one-sample t-tests were conducted to assess
the differences between the mean score of Casper’s sample and the mean score of the private
sector group and the public sector group. A significant difference was found between PRBGP
scores of Casper’s sample and private sector providers, $t(69) = -28.30, p < .001$. A significant
difference was also found between PRBGP scores of Casper’s sample and public sector
providers’, $t(68) = -32.62, p < .001$.

A one-way ANOVA was conducted to determine any differences between PRBGP total
mean scores of case managers in the public sector ($n=39$), psychologists in the public sector
($n=22$), and psychologists in the private sector ($n=69$). There were no statistically significant
differences found between these three groups, $F(2, 126) = .88, p = .42$.

To assess the difference between PRBGP scores of providers with more years of
professional experience and providers with less years of professional experience, participants
were divided at the midpoint of their reported years of experience and the two groups’ PRBGP
mean scores were compared by conducting an independent samples t-test. Reported years of
experience ranged from 0.5 year to 45 years. Participants who reported having 18 years of
experience or less were included in the first group with less years of experience and participants
with 19 years of experience or more were included in the second group with more years of
experience, with equal amounts of participants falling above and below this point. There was no
significant difference in mean PRBGP scores between these two groups, $t(137) = .51, p = .53$. A
second analysis was conducted to test the difference in PRBGP scores between professionals with
the most and least amounts of experience, comparing those with 30 or more years of experience
($n=37$) to those with five or less years of experience ($n=39$). Mean scores of these groups were
compared by conducting an independent samples t-test, which revealed no significant differences
between the two groups, $t(57.23) = .59$, $p = .57$. A bivariate correlation was also conducted to assess for a relationship between the overall mean of providers’ PRBGP scores and providers’ years of experience in the mental health care field. No significant correlation was found between these two variables, $r(N = 139) = -.03$, $p = .75$.

Independent samples $t$-tests were conducted to assess any differences between the two sectors on their mean responses to individual items on the PRBGP. Significant differences were found between public and private sector providers on their mean responses to 10 individual items on the PRBGP. Overall, no conceptual themes were found between the items of significant difference between sectors. Unequal variance was also found between two of the samples in these analyses. As a result, any interpretations of these differences would be difficult to make.

There were several significant differences between public and private sector providers in their responses to a demographic questionnaire. An analysis of the demographics data for the participants is presented in Table 1.

A factor analysis was run for the current study, which revealed eight separate factors and factor loadings for each item ranging from .22-.84. The factors on which each item loaded were different from many of the factor loadings reported by Casper et al. (2001); see Table 2. The eight factors accounted for 62.24% of the total variance (See Table 3 for variance of the separate factors). The first factor accounted for the most variance of the eight factors (21.03%). The items that loaded onto the first factor in the current study are different from the items loading onto the first factor of Casper’s study. Conceptually, four of the eight factors included items that contained similar content, adding somewhat to the reliability of the PRBGP for the current study. Specifically, the first factor related to the importance of and the capacity of the consumer to be out in the community as part of treatment; the second factor related to consumers’ preferences
and what they feel is important as an aspect of treatment; the third factor focused on working
with the consumer as based on current level of functioning; the fourth and fifth factors included
items with differing content; none of the items of the PRBGP loaded onto the sixth factor; the
seventh factor focused on the consumer easing his/her way into functioning in society; the eighth
factor included items with differing content

Discussion

The purpose of this study was to contribute to the research assessing providers’ overall
attitudes about PRI; assess any current differences between the providers in the present study and
providers from a previous study (Casper, 2005); and assess whether there are differing attitudes
between providers in the public sector of the mental health care system and providers in the
private sector.

One of the main findings of this study was the differences in psychometric properties of
the PRBGP (Casper et al., 2002) found between the current study and Casper et al.’s study
(2002). Specifically, differences were found between the number of factors that were found to
compose the PRBGP in the current study and the factors composing Casper’s study with the
current study resulting in a lower Cronbach’s alpha level. The ways in which the PRBGP items
loaded onto the factors for the current study and for Casper’s study also differed. These
psychometric differences question the reliability of the PRBGP in assessing attitudes about PRI.
It is possible that the samples for each of the studies were so different that they yielded differing
factors and alpha levels, as Casper’s sample includes participants who are part of an organization
that studies PRI. However, it is recommended that future researchers consider the reliability and
validity of this scale. The methodological issues from the current study would imply, at the
minimum that further work on the psychometric properties may need to be conducted. The main
implication of these methodological limitations is that the use of caution when considering the findings of this study is warranted. It is difficult to determine if the differences in attitudes about PRI found in the current are based on a true difference between the current study and Casper's study, or if the difference is due to a lack of reliability of the PRBGP.

Assuming that the measure used to assess attitudes about PRI is reliable, the following issues should be considered. The main objective of this study was to test whether a significant difference existed between public and private sector providers in their attitudes about PRI. Recent research (Coursey et al., 2000; Kirsh et al., 2005; Stromwall & Hurdle, 2003) found that public sector providers utilized and attempted to increase interventions and outcome measures that prescribe to the recovery model with limited use by private sector providers, suggesting that mental health care providers from the public sector may have more positive attitudes about PRI than private sector providers. The current study found that private sector providers reported significantly less experience treating individuals with serious mental illness over the course of their practice compared to public sector providers. Despite the findings discussed above (Coursey et al., 2000; Kirsh et al., 2005; Stromwall & Hurdle, 2003) as well as the public sector providers from this study having more experience with SMD individuals, there was no difference between public and private sector providers in their attitudes about PRI with participants in both sectors having neutral mean scores.

Another main finding of the current study was that the overall mean PRBGP scores of the current study were significantly lower than the overall mean PRBGP score of Casper's study (2005). This indicates that mental health care providers from the current sample have less favorable attitudes than the sample from Casper's study, which took place four years ago. This finding might suggest the possibility that the providers in Casper's study have more positive
attitudes about PRI and that PRI is more widely utilized by Casper’s sample (participants involved in an organization utilizing PRI from 39 states, but the specific states were not listed).

One of the secondary hypotheses for this study assessed whether there was a difference in attitudes about PRI between providers with more experience in the mental health care field and those with less experience. Because of the increase in the last few decades in the literature about the effectiveness of PRI, it could be hypothesized that more newly educated and trained individuals may hold more positive attitudes about PRI than their more experienced peers. However, there were no differences between these groups (with both groups having neutral attitudes). It seems plausible that because there is more current research that supports the effectiveness of PRI (Farkas et al., 2005; Gilbert et al., 2003; Hellkamp, 1993a; Lehman et al., 2004), newer trained providers would receive more education about these interventions and thus develop positive attitudes about the focus of PRI in assisting SMD individuals back to recovery. However, both groups in this study had neutral attitudes, neither positive nor negative.

Despite the significant differences between public and private sector providers with regards to a number of variables, including profession, education, years in profession, setting, and reported exposure to PRI, there were no significant differences between sectors in their attitudes about PRI (with all provider scores in the neutral range). There were also no differences in these attitudes between the three groups most representative of the total sample (including 69 psychologists from the private sector, 22 psychologists from the public sector, and 39 case managers from the public sector). It appears that attitudes regarding PRI are consistent across various groups of professionals in this sample, with all provider scores in the neutral range.

A possible explanation for the difference in scores between the current sample and Casper’s sample is the increase in budget cuts for mental health care treatment (SMHA, 2008).
Without having the direct experience of treating SMD individuals with PRI, it is possible that positive attitudes are difficult for providers to develop. An additional possible explanation for neutral PRBGP scores is the belief that SMD individuals are too impaired to participate in psychosocial treatment of their illness (Dhillon & Dollieslager, 2000). This belief is inconsistent with the main theoretical underpinnings of PRI, the recovery model. This general attitude system is one that is measured by the PRBGP, which showed no difference between providers who are treating SMD individuals and those who are not. On the other hand, a past study (Casper, 2005) found that positive attitudes of providers did positively correlate with positive outcomes and quality of life of those providers’ patients. With this in mind, it seems possible that this general attitude, SMD individuals are unable to function in society, may serve as a self-fulfilling prophecy for the patients being treated by these providers. Also, this study was conducted during a severe economic recession as opposed to Casper’s (2005) study, which was conducted during less trying times economically. The condition of the economy as an influence on the difference between providers’ attitudes about PRI from the current sample and Casper’s might be considered for future research. This particular time period thus far has been characterized by many cuts in various health care services, mental health care being amongst those experiencing the most cuts (SMHA, 2008). Similarly, it is possible that providers who hold a strong belief in solely treating SMD individuals pharmacologically would fail to recognize the need to advocate for or utilize PRI when treating this population. Because of the prominent focus on medication, which may continue to increase with cuts on PRI services, it is possible that mental health care providers’ perceptions of the importance of PRI for treatment of SMD clients may remain neutral.

Based on the psychometric concerns discussed earlier, it is important to interpret the results as well as the possible explanations for the results with caution.
Implications

The main implication of the results of this study, as stated above, is that the findings and issues discussed above regarding the attitudes about PRI of mental health care providers in both sectors be considered with caution. This information can only be useful to the current literature assuming that the PRBGP is a reliable and valid measure of the general attitudes about PRI of mental health care providers.

Assuming that the measure used to assess attitudes about PRI is reliable, the following implications of the results of this study should be considered. According to literature published over the last few years, the amount of research on psychosocial rehabilitation interventions for the treatment of individuals with serious mental illness has increased. With this increase in research, the available knowledge about the main tenets of these interventions as well as empirical support of the effectiveness of these interventions has also increased. However, the actual use of PRI has not increased and the majority of the treatment of SMD individuals remains in the hands of antipsychotic medication, placing minimal focus on psychosocial treatment (Lehman et al., 2004; Stroup et al., 2006). It is possible that without much use of PRI, the current research may decrease, thus decreasing the research that is available to educate providers about the principles and importance of PRI and improve their attitudes about using PRI to treat SMD individuals.

In a post-hoc examination of the responses provided by providers on an open-ended question on the demographic questionnaire, 20 respondents (12%) provided additional suggestions about how PRI services could be improved or more widely used. Many of these respondents provided suggestions regarding the need for more education, research, and public knowledge about the principles and outcomes of PRI as well as PRI becoming an essential part of the continuum of care on a country board level. Respondents also suggested the need for
adjustments and increases in insurance policies that allow for PRI services to be received by more individuals. The providers’ suggestions address some of the key issues that seem to contribute to low rates of use of PRI. This suggests that the providers may be aware of some of the problems involved in implementing PRI, however as based on the neutral overall mean score of provider attitudes about PRI ($M = 75.58$, $SD = 6.31$), these providers may not be as fully informed as other providers about the principles of PRI as well as the principles of the recovery model and capabilities of SMD individuals despite their illness.

Consequently, it seems that both private and public sector providers might benefit from more education about the principles and effectiveness of PRI as well as education about serious mental illness in general. Based on the results of this study, it seems that these providers may be less knowledgeable than other mental health care providers (Casper, 2005) in the treatment of a challenging population, SMD individuals. More of a focus in the training of public sector providers in PRI principles may improve SMD treatment, as these individuals were found to be the main professionals providing treatment to SMD individuals.

Limitations

As discussed above, the utility of the results of this study are questionable as based on the unclear psychometric properties of the PRBGP, the measure used to assess attitudes about PRI, which is the most significant limitation of the current study. The limitations discussed below are considered under the assumption that the PRBGP is a reliable measure.

Another limitation of this study was that not all of the major mental health professions were represented in the sample, including psychiatrists, psychiatric nurses, social workers, and other mental health care providers. Moreover, the majority of respondents were psychologists and case managers. As a result, it is difficult to make solid conclusions about private and public sector
providers in general in terms of their attitudes; these results mainly speak to the attitude systems of case managers and psychologists. Although psychologists are highly representative of private sector providers and case managers highly representative of public sector providers, it would have been beneficial for this study to include a wider, more representative range of mental health care providers in order to make more conclusive statements about mental health care providers’ attitudes about PRI.

Finally, private sector providers indicated that they had significantly less experience with the SMD population than public sector providers, so likely have less exposure to PRI. Although one of the goals of the PRBGP (Casper et al., 2002) was to assess providers’ knowledge about PRI, their lack of experience with SMD individuals could have impacted their scores on this measure. However, this conclusion was difficult to support, as based on the similar PRBGP scores of the private sector providers, who had minimal experience with SMD individuals, and the public sector providers, who had much more experience with SMD individuals.

**Future Research**

The main recommendation for future research would be to revisit the reliability and validity of the PRBGP in measuring attitudes about PRI so as to reestablish psychometric properties. Without sound psychometric properties established for this measure, the utility of measuring the attitudes of mental health care providers about PRI with the PRBGP is questionable. Revisiting the psychometrics of this measure can provide clearer information about whether this measure is actually an unreliable one, or whether the major differences between the psychometric properties of these measures are due to such vastly differing samples of providers.

Assuming the PRBGP is reliable, the current study contributed information to the literature regarding the attitudes about PRI of providers during a time of severe economic
recession. Some possibilities were discussed (i.e., budget cuts in mental health care leading to less exposure to PRI; negative attitudes about the capabilities of SMD individuals) as to why there were no differences between private and public sectors as well as why it is that providers' overall scores were much lower than providers' from a past study. It would be beneficial for future researchers to study these possibilities.

Also, it would be beneficial for more comprehensive research to be conducted. This would include a greater representation of all of the different mental health care providers so as to obtain more conclusive information about each of the sectors of the mental health care system in terms of provider attitudes about PRI. Data collection from a wider range of locations, including states outside of, as well as, Ohio would provide more comprehensive information about both private and public sector providers. It would also be informative to make comparisons between different cities, states, counties, etc to get a clearer picture of whether a particular area is lacking in positive attitudes about PRI or whether providers in general have decreased in this regard, as possibly based on current economic stress.
References


### Table 1

*Demographic Data of Providers in the Private and Public Sectors*

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<td>n</td>
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<td>19 years or less</td>
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<td>58</td>
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<td></td>
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<td><strong>Trained in PRI</strong></td>
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<td></td>
<td></td>
<td></td>
<td>p &lt; .05**</td>
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<td>Not at all*</td>
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<td>7.10</td>
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<td><strong>Training at UC or XU consortium on SMD?</strong></td>
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*p ≤ .001*

*p ≤ .05**

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Table 2

Factor Loadings for the Psychiatric Rehabilitation Belief, Goals, and Practices

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<th>6</th>
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<td>Item 8 * Not comfortable with client in consumer group</td>
<td>.78</td>
<td>.14</td>
<td>.15</td>
<td>-.07</td>
<td>.03</td>
<td>-.08</td>
<td>-.01</td>
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<td>Item 9 * Pple with mental illness more protection from society</td>
<td>.84</td>
<td>.10</td>
<td>.09</td>
<td>.03</td>
<td>.004</td>
<td>-.01</td>
<td>-.007</td>
<td>.04</td>
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<tr>
<td>Item 12* Pple with mental illness lack personal preference</td>
<td>.75</td>
<td>.10</td>
<td>.28</td>
<td>.04</td>
<td>-.01</td>
<td>.02</td>
<td>.03</td>
<td>.02</td>
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<tr>
<td>Item 13* Competitive work too stressful for mentally ill pple</td>
<td>.58</td>
<td>.20</td>
<td>.40</td>
<td>-.16</td>
<td>.06</td>
<td>.23</td>
<td>.09</td>
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<td>Item 22* Outcomes of PR not worth the cost and complexity</td>
<td>.81</td>
<td>.08</td>
<td>.05</td>
<td>.01</td>
<td>-.03</td>
<td>-.02</td>
<td>.05</td>
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<tr>
<td>Item 25* Capacity to learn/grow diminished in mentally ill pple</td>
<td>.79</td>
<td>.14</td>
<td>.08</td>
<td>.24</td>
<td>.04</td>
<td>-.04</td>
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<td>Item 6 * Mentally ill person’s housing, etc same as person w/o illness</td>
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<td>-.12</td>
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<td>Item 7 I rely on client’s preferences when exploring housing</td>
<td>-.004</td>
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<td>-.20</td>
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<td>Item 10 My choices for pple w/ mental illness same as for w/o</td>
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<td>.49</td>
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<td>Item 14 * Stable client living in own home is a proper PR goal</td>
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<td>Item 19 Pple with mental illness would choose the same as anyone</td>
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<td>.46</td>
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<td>-.15</td>
<td>.09</td>
<td>-.06</td>
<td>.08</td>
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<td>Item 20 Client’s preferences direct every aspect of rehab planning</td>
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<td>.68</td>
<td>-.005</td>
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<td>.12</td>
<td>-.17</td>
<td>-.19</td>
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<td>.64</td>
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<td>.09</td>
<td>.12</td>
<td>-.35</td>
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<td>Item 15* Rehab plan for work should include gradual steps</td>
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<td>.11</td>
<td>.22</td>
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<td>Item 17 * Supports in job, house should be time limited</td>
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<td>.02</td>
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<td>.55</td>
<td>.48</td>
<td>.33</td>
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<td></td>
<td>1</td>
</tr>
<tr>
<td>Item 1 Support dvlpmnt more important than skill training</td>
<td>-.02</td>
</tr>
<tr>
<td>Item 5 Helping clients new positive self-image is a viable PR goal</td>
<td>-.20</td>
</tr>
<tr>
<td>Item 18 Educate mentally ill person on their tx helps cooperation</td>
<td>-.05</td>
</tr>
<tr>
<td>Item 4 *PR is a process where client should discuss all decisions</td>
<td>.14</td>
</tr>
<tr>
<td>Item 16 Recovery involves exposing person to risks of relapse</td>
<td>-.07</td>
</tr>
<tr>
<td>Item 3 *Can judge how well a client ill do in work by residence</td>
<td>-.13</td>
</tr>
<tr>
<td>Item 11 PR providers should be as concerned with quality of life as w</td>
<td>-.07</td>
</tr>
</tbody>
</table>

*Items are reversed scored
Table 3

Total Variance of the Psychiatric Rehabilitation Beliefs, Goals, and Practices Factors

<table>
<thead>
<tr>
<th>Factor</th>
<th>Total</th>
<th>% of Variance</th>
<th>Cumulative %</th>
</tr>
</thead>
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<td>5.47</td>
<td>21.03</td>
<td>21.03</td>
</tr>
<tr>
<td>2</td>
<td>3.03</td>
<td>11.66</td>
<td>32.69</td>
</tr>
<tr>
<td>3</td>
<td>1.70</td>
<td>6.43</td>
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</tr>
<tr>
<td>4</td>
<td>1.35</td>
<td>5.18</td>
<td>44.30</td>
</tr>
<tr>
<td>5</td>
<td>1.30</td>
<td>4.84</td>
<td>49.14</td>
</tr>
<tr>
<td>6</td>
<td>1.18</td>
<td>4.55</td>
<td>53.69</td>
</tr>
<tr>
<td>7</td>
<td>1.15</td>
<td>4.43</td>
<td>58.12</td>
</tr>
<tr>
<td>8</td>
<td>1.07</td>
<td>4.12</td>
<td>62.24</td>
</tr>
</tbody>
</table>
Appendix A

The Psychiatric Rehabilitation Beliefs, Goals, and Practices (PRBGP) is protected by copyright so it is not reproduced in this document. This measure is available through the author, Edward S. Casper, who can be reached at the following address: 520 Second Avenue Apt. 20A, New York, NY 10016.
Appendix B

Demographic Questionnaire

1. In what type of setting do you primarily work? (Please check only one.)

___ Private practice
___ Community mental health center
___ State psychiatric hospital
___ Private psychiatric hospital
___ Case management program
___ Other (please specify) ___________________________

2. What is your profession?

___ Case Manager
___ Psychologist
___ Psychiatric Nurse
___ Psychiatrist
___ Physician (not psychiatrist)
___ Social worker
___ Counselor
___ Other (please specify)

3. How many years have you worked in this profession?

___

4. Education (Degree):

___ High School
___ Associates
___ Bachelors
___ Masters
___ Doctoral
___ Medical

5. In your professional training, were you taught psychosocial rehabilitation intervention skills and concepts?

___ Not at all
___ Yes, but not in depth
___ Yes, on a conceptual level
___ Yes, on a conceptual level and under supervision in an applied manner
6. If you trained at the University of Cincinnati or Xavier University in your graduate training, were you a member of the Multidisciplinary Training Program Consortium on severe mental disorders, funded by ODMH? Yes____ No____

7. Throughout the course of being in practice, what percentage of the individuals with which you worked would you consider being severely mentally ill? ________

What percentage of the individuals with which you work currently would you consider being severely mentally ill? ________

8. How do you think Psychosocial Rehabilitation Interventions could be improved or more widely used? (Check all that apply)

___ Increase available funding
___ Improve training for PRI
___ Education for practitioners
___ Increase knowledge of efficacy of PRI
___ Other (please specify) ____________________________

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Appendix C

Xavier University IRB Letter of Approval

September 24, 2008

Gina Muehlheim, MA
2750 Linshaw Court
Apt. 5
Cincinnati, Ohio 45208

Dear Ms. Muehlheim,

The IRB reviewed your protocol #0539-1, Private and Public Sector Providers' Attitudes and Beliefs about Psychosocial Rehabilitation Interventions. Your study has been determined to meet criteria for the Exempt from Review category. Your protocol is approved as exempt research, and therefore requires no further oversight by the IRB.

If you wish to modify your study, it will be necessary to obtain IRB approval prior to implementing the modification.

We wish you success with your research!

Sincerely,

Kathleen J. Hesp, Ph.D.
Interim Chair

C. Dr. David T. Hellkamp, Faculty Advisor
Appendix D
Informed Consent

I agree to take part in this study conducted by Gina M. Muehlheim, M.A., a doctoral student in clinical psychology from Xavier University. This study examines attitudes, beliefs, and knowledge about Psychosocial Rehabilitation Interventions. Participation in this study will contribute information to the literature to help improve psychosocial treatment of individuals with severe mental illnesses.

I understand that participation in this study is completely voluntary and I may choose to cease participation at any time.

If you have any questions about this project, Gina Muehlheim can be reached at 330-310-2208. Her research is supervised by David T. Hellkamp, Ph.D., Professor of Psychology, Xavier University, who can be reached at 513-745-1044.

Your name and responses to this study are completely confidential. The results will be reported in group formats. No individual names or scores will be identified.

I understand that I will not receive any financial compensation for my participation in this study. By participating, I will be promoting knowledge regarding Psychosocial Rehabilitation Interventions.

I fully understand the nature of this study and agree to participate. My consent is implied through my participation.
Appendix E

Cover Letter for Private Sector

Dear Ohio practicing psychologists,

Enclosed you will find a survey that asks you to answer questions regarding your attitudes, beliefs, and knowledge about Psychosocial Rehabilitation Interventions as well as some questions about your professional training and experience. We would like to encourage you to take the 5 minutes or less to complete this survey. When you are finished, place it in the self-addressed envelope and mail it back as soon as possible. We want to thank you in advance for your participation.

Sincerely,

Gina Muehlheim, M.A.
Doctoral Student in Clinical Psychology
Xavier University
Student Member of OPA

David T. Hellkamp, Ph.D.
Professor of Psychology
Xavier University
Former President of OPA
November 23, 2009

Gina Mulheim
2550 Second Street Apt. 308
Cuyahoga Falls, OH 44221

Dear Ms. Mulheim,

This letter is to confirm that the Talbert House Affiliation did review and approve your research proposal titled “Private and Public Sector Providers’ Attitudes and Beliefs about Psychosocial Rehabilitation Interventions.” Our Human Subjects Committee granted approval on December 4, 2008. The approval for this project expires on December 4, 2009. If the project has not been completed by this date, you will need to submit a written request to the Talbert House Human Subjects Committee for a continuation. If you have any questions, please contact me at 513-751-7747.

Sincerely,

Kimberly Gentry Sperber, Ph.D.
Chief Research Officer

cc: CQI Files
Appendix G

Cover letter for Public Sector

Dear Talbert House Professionals,

Enclosed you will find a survey that asks you to answer questions regarding your attitudes, beliefs, and knowledge about Psychosocial Rehabilitation Interventions as well as some questions about your professional training and experience. We would like to encourage you to take the 5 minutes or less to complete this survey. When you are finished, place it in the self-addressed envelope and mail it back as soon as possible. We want to thank you in advance for your participation.

Sincerely,

Gina Muehlheim, M.A.
Doctoral Student in Clinical Psychology
Xavier University

David T. Hellkamp, Ph.D.
Professor of Psychology
Xavier University
Summary

Title: Private and Public Sector Providers' Attitudes about Psychosocial Rehabilitation Interventions

Problem: Recent literature has identified the use of Psychosocial Rehabilitation Interventions (PRI) as becoming more of a necessity to treatment of individuals with severe mental disorders (Farkas, et al., 2005; Gilbert et al., 2003; Hellkamp, 1993a; Lehman et al., 2004); however, other literature (Gilbert et al., 2003) suggested that PRI still may not be a widely used intervention by providers who treat individuals with severe mental disorders. Smith and Bartholomew (2006) discussed the importance of the influence that attitudes can play in the decision making process of mental health care providers who work with the severely mentally disabled population. Smith and Bartholomew (2006) suggested that the largest hurdle in the process of treating individuals of this population with the goal of recovery is dealing with the attitudes that are present in providers working with this population. Several studies have suggested that attitudes about PRI is a valuable component to a better understanding of the use of PRI and the providers who implement these interventions (Casper, 2005; Cnann & Blankertz, 1992; Song, 2007). However, there has not been a lot of research on the attitudes about PRI of these providers.

Method: This study utilized data from 139 mental health care providers in the state of Ohio who practice in the private and public sectors of the mental health care system. The Psychiatric Rehabilitation Beliefs, Goals, and Practices (PRBGP) was used to measure the attitudes of mental health care providers in both sectors about PRI. A demographics questionnaire was also used to obtain demographic information for each participant. Data was collected by sending surveys in
the mail to OPA members as well as collecting data from providers of a large local mental health agency during staff meetings.

Findings: Various psychometric differences were found on the PRBGP scale between the current study and a previous study (Capser, 2005), including differences between the number of factors that composed the PRBGP, a lower Alpha level for the current study, and the ways in which the PRBGP items loaded onto the factors of the PRBGP. These psychometric differences question the reliability of the PRBGP in assessing attitudes about PRI. Assuming the PRBGP is a reliable measure, results revealed no significant difference between private and public sector providers’ attitudes about PRI, with both groups reporting neutral attitudes. This study also revealed less positive attitudes than a previous study (Casper, 2005) with lower attitudes for both private and public sector providers. No significant differences were found between providers with varying years of experience or between case managers, public sector psychologists, and private sector psychologists.

Implications: The main implication of the results of this study is that the findings regarding the attitudes about PRI of mental health care providers in private and public sectors should be considered with caution. This information can only be useful to the current literature assuming that the PRBGP is a reliable and valid measure of the general attitudes about PRI of mental health care providers. The factor analysis of the scale in the present study raises question about the reliability of the psychometric properties. When assuming this a reliable measure, the analysis of the current data indicated that both private and public sector providers might benefit from more education about PRI. These providers would also benefit from more education about serious
mental illness in general, including the capabilities of SMD individuals in regard to treatment. More of a focus in the training of public sector providers in PRI principles may improve the treatment of individuals with severe mental disorders, as these individuals were found to be the main professionals providing treatment to SMD individuals.